TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS ORTHOPEDIC HOSPITAL

Respondent Name
LM INSURANCE CORP.

MFDR Tracking Number
M4-18-0628-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
November 9, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim should have been paid in accordance with 28 T.A.C. § 134.403, which states, '(1) [t]he sum of the Medicare facility specific reimbursement amount and any applicable outlier amount shall be multiplied by (A) 130 percent . . . '. In addition to reimbursement that the Fee Schedule provides for implants."

Amount in Dispute: $3,348.97

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Initially, there was no request for implant payment to be made separately. To date, we have not received the implant invoices. When inf9ormation necessary for implant payment has not been received, the payment should be at the higher rate per direction from the State of TX."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
May 17, 2017	Outpatient Hospital Services	$3,348.97	$3,348.97

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - X936 – CPT OR HCPC IS REQUIRED TO DETERMINE IF SERVICES ARE PAYABLE. (X936)
   - 196 – CPT OR HCPC IS REQUIRED TO DETERMINE IF SERVICES ARE PAYABLE. (X936)
   - W3 – CPT OR HCPC IS REQUIRED TO DETERMINE IF SERVICES
   - U634 – PROCEDURE CODE NOT SEPARATELY PAYABLE UNDER MEDICARE AND OR FEE SCHEDULE GUIDELINES. (U634)

- Z652 – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED. (Z652)
- P303 – THIS SERVICE WAS REVIEWED IN ACCORDANCE WITH YOUR CONTRACT. (P303)
- MOPS – SERVICES REDUCED TO THE OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS)
- MCMP – THE FINAL RECOMMENDED REIMBURSEMENT FOR CMS HOSPITAL OUTPATIENT APC COMPOSITE IS REFLECTED ON THIS LINE. (MCMP)
- Z547 – ANY REDUCTION IS IN ACCORDANCE WITH A COVENTRY OWNED CONTRACT. FOR QUESTIONS CALL 1-800-937-6824 OR ATTN: PROVIDER SERVICES: 3611 QUEEN PALM DRIVE, SUITE 200, TAMPA, FL 33619. THIS REIMBURSEMENT MAY REFLECT PAYMENT AT RATES LESS THAN THE STATE FEE
- MJ1N — RECOMMENDED REIMBURSEMENT IS BASED ON CMS HOSPITAL OUTPATIENT STATUS INDICATOR J1: COMPREHENSIVE APC NON-COMPLEXITY ADJUSTMENT. (MJ1N)
- MX70 – PER NCCI, THE PROCEDURE CODE IS DENIED DUE TO MISUSE OF COLUMN 2 CODE WITH COLUMN 1 CODE. PROCEDURE INCLUDED IN 64415. (MX70)
- ESE1 – ACCORDING TO CMS RULES, STATUS INDICATOR E1 SERVICE ARE NOT COVERED SERVICES. (ESE1)

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the recommended payment for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. Neither party submitted documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. Accordingly, the disputed services are reviewed according applicable division rules and fee guidelines.
2. This dispute regards outpatient hospital facility services with payment subject to 28 Texas Administrative Code §134.403, requiring the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount applying the effective Medicare Outpatient Prospective Payment System (OPPS) formula and factors, published annually in the Federal Register, with modifications as set forth in the rule. Medicare OPPS formulas and factors are available from the Centers for Medicare and Medicaid Services (CMS) at http://www.cms.gov.

   Rule §134.403(f)(1) requires that the sum of the Medicare facility specific amount and any applicable outlier payment be multiplied by 200 percent, unless a facility requests separate payment of implantables.

   While the requestor's position statement asks for payment at the 130% payment adjustment factor (PAF) with separate reimbursement of implantables, the provider did not submit any evidence to support that separate reimbursement of implantables was requested during claim submission.

   Rule §134.403(g)(1) requires that:

   > A facility . . . billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

   The requestor did not submit a copy of the signed certification required by rule §134.403(g)(1). Nor did the requestor submit documentation to support the cost of the implantables to the facility. As the requestor has not met the requirements of Rules §134.403(f) and (g) to support separate reimbursement of implantables, payment is instead calculated at the 200% PAF—without any separate payment for implantables.

   Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) to billed services based on procedure code and supporting documentation. The APC determines the payment rate. Payment for ancillary items and services is packaged into the APC payment. CMS publishes quarterly APC rate updates, available at www.cms.gov.

Reimbursement for the disputed services is calculated as follows:

- Procedure codes J2370, J2704, C1713, J0690, J0735, J1100, J2250, J2405, J2795, and J3010 have status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
- Procedure code 29827 has status indicator J1, denoting packaged services paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure (except those with status indicator F, G, H, L or U; certain inpatient and preventive services; ambulance and mammography). This is assigned APC 5114. The OPPS Addendum A rate is $5,221.57, which is multiplied by 60% for an unadjusted labor-related amount of $3,132.94, in turn multiplied by the facility wage index of 0.9653 for an adjusted labor amount of $3,024.23. The non-labor related portion is 40% of the APC rate, or $2,088.63. The sum of the labor and non-labor portions is $5,112.86. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the fixed-dollar threshold of $3,825, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.105. This ratio is multiplied by the billed charge of $3,297.75 for a cost of $346.26. The sum of packaged costs is $5,158.39, which is added to the service cost for a total cost of $5,504.65. The cost of services exceeds the fixed-dollar threshold of $3,825. However, the amount by which the cost exceeds 1.75 times the OPPS payment is $0.00; the services are thus not eligible for outlier payment. The Medicare facility specific amount is $5,112.86.

  The division notes that this amount calculated as the Medicare fee matches the amount calculated by the insurance carrier as the "claim amount" as listed on page 2 of the respondent's *Out-Patient Case Summary* worksheet — included with the carrier's response.

  The Medicare facility specific amount of $5,112.86 is multiplied by the division's payment adjustment factor of 200% (for outpatient hospital services without separate payment of implants) for a total MAR of $10,225.72.
- Per Medicare policy, procedure code 29828 has status indicator J1, denoting packaged services paid at a comprehensive rate. All covered services on the bill are packaged with the primary J1 procedure. When multiple designated J1 procedures are performed together, only the highest-ranking J1 status procedure is paid. This procedure is *not* the primary J1 service on this bill; payment for this code is packaged with J1 status code 29827, above.
- Procedure code 29826 is packaged with procedure code 29827 with J1 status billed on the same claim.
- Per Medicare policy regarding NCCI edits, procedure code 64415 may not be reported with codes 29827, 29828 or 29826 billed on the same claim. Reimbursement for this service is included with payment for the primary procedure(s). Separate payment is not recommended.
- Procedure codes G8984, G8985, and G8986 have status indicator E1, denoting excluded or non-covered codes not payable on an outpatient bill. Payment is not recommended.
- Procedure code 97161 represents a physical therapy evaluation with status indicator A. Therapy services are packaged with the primary comprehensive J1 procedure, code 29827, above.

3. The total recommended reimbursement for the disputed services is $10,225.72. The insurance carrier has paid $3,297.75. The requestor is seeking additional reimbursement of $3,348.97. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the available evidence presented by the requestor and respondent at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $3,348.97.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $3,348.97, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	December 14, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (form DWC045M) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.